IPDR6702				NORTH CAROLINA		PA	AGE: 1	
RUN DATE	: 12/06/2005		II	PRS CHECKWRITE SUMMARY REPORT CHECKWRITE DATE: 12/06/2005				
				FINANCIAL PAYER: NCDMH				
							TOTAL	TOTAL
PROVIDER NUMBER		HIGH DENIAL EOBS	NUMBER OF DENIALS	DESCRIPTION	TNC	TOTAL	CLAIMS	CLAIMS
NOPIDER	PROVIDER NAME	EODS	DENTALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404901	SMOKY MOUNTAINM	10	4	DIAGNOSIS OR SERVICE INVALID F				
	H/DD/SAS			OR CLIENT AGE. VERIFY CID,				
				DIAGNOSIS, PROCEDURE CODE FOR				
		0	0				4	
				+		0 4	4	-
3404904	WESTERN HIGHLAN	8599	45	DETAIL NOT COVERED BY COMBINAT				
	DS LME			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		21	42	DUPLICATE OF CLAIM-SYSTEM		0 137	6064	592
						0 157	0004	332
		191	17	CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME				
			+	A LALLENI NAME			-	
			+		+			
3404910	PATHWAYS	8505	320	CLAIM DENIED DUE TO INSUFFICIE				<u> </u>
				NT BUDGET				
		11	200	CLIENT NOT ELIGIBLE ON SERVICE	+	0 610	62.44	E 4 0
	+			DATE		0 649	6144	549
		8535	48	SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837.				
				PLEASE RESUBMIT YOUR CLAIM WIT				
3404912	CATAWBA COUNTYM	8599	77	DETAIL NOT COVERED BY COMBINAT				
	ENTAL HEALT			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		11	44	CLIENT NOT ELIGIBLE ON SERVICE		2 147	2163	201
				DATE		211	2203	201
		191	11	CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME				
				H FAITENI NAME				
3404913	MECKLENBURG COM	11	986	CLIENT NOT ELIGIBLE ON SERVICE				
	ENTAL HEALT			DATE				
		8933	40	ADTNC INELIGIBLE TO RECEIVE SE	4	10 1026	1026	
			1	RVICES IN IPRS.		1320	1320	<u> </u>
3404916		0		AND DAMA TO DEPORT AND				
7404219	CROSSROADS BEHA	0	U	*** NO DATA TO REPORT ***	+			
	VIORAL HEAL		+		+			
			1					
		0	0			0 0	0	
		1						
		_				1		
3404917	CEMBER DOTAIN WAY	11	1176	CLIENT NOT ELIGIBLE ON SERVICE				i i
3404917	CENTERPOINT HUM AN SERVICES	11	1176	CLIENT NOT ELIGIBLE ON SERVICE DATE				
3404917	CENTERPOINT HUM AN SERVICES	11	1176					
3404917				DATE				
3404917		8599	1176	DATE DETAIL NOT COVERED BY COMBINAT	1	17 1573	3146	157
3404917				DATE	1	17 1573	3146	157:
3404917				DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND	1	17 1573	3146	157
3404917				DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND	1	17 1573	3146	157:
3404917		8599	160	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR	1	17 1573	3146	157:
3404917		8599	160	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND	3	17 1573	3146	157:
	AN SERVICES	8599	160	DATE DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE	1	17 1573	3146	157
3404917	AN SERVICES ROCKINGHAM CO M	8599	160	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR	1	1573	3146	157:
	AN SERVICES	8599	160	DATE DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE	3	1573	3146	157
	AN SERVICES ROCKINGHAM CO M	8599	160	DATE DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE	3	1573	3146	157
	AN SERVICES ROCKINGHAM CO M	8599	160	DATE DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE	1	1573		

PROVIDER		UVOU DENIVAY	WHEN A				TOTAL	TOTAL
		HIGH DENIAL	NUMBER OF	DECONTRETON	TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404919	GUILFORD CO MEN	79	120	THIS SERVICE IS NOT PAYABLE TO				
3404919	TAL HEALTHC		120	YOUR SUBMITTED BILLING				
	TAL REALINC			PROVIDER TYPE AND SPECIALTY IN				
		8599	96	DETAIL NOT COVERED BY COMBINAT	82	521	8614	8093
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8534	88	SERVICE FACILITY LOCATION IS N				
				OT A VALID IPRS ATTENDING				
				PROVIDER. PLEASE VERIFY THE F				
3404920		8505	2192	CLAIM DENIED DUE TO INSUFFICIE				
3404920	ALAMANCE CASWEL	6303	2192	NT BUDGET				
	L AREA MH D			11 202021				
		11	181	CLIENT NOT ELIGIBLE ON SERVICE	3	2649	3059	410
				DATE		2013	5055	110
		8599	149	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
			1					
3404921	ORANGE PERSON C	5312	669	PRIOR AUTHORIZED DOLLARS EXCEE				
	HATHAM AREA			DED				
	1	8505	382	CLAIM DENIED DUE TO INSUFFICIE		1		
		6303	302	NT BUDGET	26	1812	4292	2480
				NI BODGET				
		8800	379	FURTHER PROCESSING NECESSARY,				
				PLEASE CHECK FOR CLAIM ON				
				FUTURE RA'S.				
3404922	THE DURHAM CENT	0	0	*** NO DATA TO REPORT ***				
	ER							
		0	0		0	0	0	0
3404923	FIVE COUNTY MH	8329	3005	CLAIM DENIED ATTENDING PROVIDE				
				R CANNOT BE THE SAME AS				
				THE LMA				
		1.1	0.2.2	CLIENT NOT ELIGIBLE ON SERVICE				
		11	933	DATE	1	4267	6170	1903
				DATE				
		21	101	DUPLICATE OF CLAIM-SYSTEM				
	1							
	1							
3404925	SANDHILLS CENTE	8518	818	CLAIM DENIED, SUBMITTED BEYOND				
	R FOR MH/DD			FILING TIMELIMIT. PRIOR				
				FISCAL YEAR DOS (JULY 1 - JUNE				
		8534	551	SERVICE FACILITY LOCATION IS N	38	2397	6058	3661
				OT A VALID IPRS ATTENDING				
				PROVIDER. PLEASE VERIFY THE F				
		8599	203	DETAIL NOT COVERED BY COMBINAT				
	_			ION OF RECIPIENT, PROVIDER AND				
	1		_	BENEFIT PACKAGE.		1		
3404926	001100100000000000000000000000000000000	11	1466	CLIENT NOT ELIGIBLE ON SERVICE				
J101320	SOUTHEASTERN RE	11	1400	DATE				
	G MENTAL HL							
	+							
	1	8599	154	DETAIL NOT COVERED BY COMBINAT	106	2211	9131	6920
	1		-	ION OF RECIPIENT, PROVIDER AND	106	2211	9131	0320
	+			BENEFIT PACKAGE.				
	1		+					
	+	8535	138	SERVICE FACILITY LOCATION WAS				
	1			NOT INCLUDED IN YOUR 837.				
	1			PLEASE RESUBMIT YOUR CLAIM WIT	+			l
				PLEASE RESUBMIT YOUR CLAIM WIT				

DE CLIVE DE D		UVOU DENVINA					TOTAL	TOTAL
PROVIDER NUMBER	DE CLUEDED MANEE	HIGH DENIAL EOBS	NUMBER OF DENIALS	DESCRIPTION	TNC	TOTAL	CLAIMS	CLAIMS
NOMBER	PROVIDER NAME	EODS	DENTALS	DESCRIFITON	DENIALS	DENIALS	FINALIZED	PAID
3404927	CUMBERLAND CO M	21	71	DUPLICATE OF CLAIM-SYSTEM				
	HC							
		8599	57	DETAIL NOT COVERED BY COMBINAT		242	4021	3778
				ION OF RECIPIENT, PROVIDER AND	6	243	4021	3778
				BENEFIT PACKAGE.				
		11	29	CLIENT NOT ELIGIBLE ON SERVICE				
				DATE				
3404929	LEE HARNETT MH/	0	0	*** NO DATA TO REPORT ***				
	DD/SAS							
		0	0			0	0	
						0	0	0
3404930	JOHNSTON COUNTY	8505	62	CLAIM DENIED DUE TO INSUFFICIE				
	MNTL HLTHC			NT BUDGET				
	1	11	9	CLIENT NOT ELIGIBLE ON SERVICE	3	80	157	77
				DATE			137	L ¨
		21	4	DUPLICATE OF CLAIM-SYSTEM	1	1		
		21	*	SOLDICATE OF CHAIN-SISIEM	1	 		
		1						
3404931	WAKE CO HUM SVC	8534	452	SERVICE FACILITY LOCATION IS N				
	BILLING OF			OT A VALID IPRS ATTENDING PROVIDER. PLEASE VERIFY THE F				
				PROVIDER: PLEASE VERIFI INE F				
		8599	283	DETAIL NOT COVERED BY COMBINAT	217	1651	19100	17449
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8621	153	60 RESIDENTIAL LEVEL III TREAT				
		0021	133	MENT RECEIVED, PA IS REQUIRED				
				FOR ADDITIONAL SERVICE.				
3404932	RANDOLPH/SANDHI	0	0	*** NO DATA TO REPORT ***				
	LLS CO MH C							
		0	0		0	0	0	0
3404933	SOUTHEASTERN CT	8599	225	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND				
	R FOR MH/DD			BENEFIT PACKAGE.				
		11	65	CLIENT NOT ELIGIBLE ON SERVICE	0	409	761	352
				DATE				
		-			1			
		8621	62	60 RESIDENTIAL LEVEL III TREAT				
				MENT RECEIVED, PA IS REQUIRED				
				FOR ADDITIONAL SERVICE.				
3404934		0500	666	DETAIL NOT COURDED BY COMPANIE		1		
3404934	ONSLOW CARTERET BEHAV HEAL	8599	666	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND	-	 		
	DERAY REAL	1		BENEFIT PACKAGE.	1	1		
		11	362	CLIENT NOT ELIGIBLE ON SERVICE	103	1894	8595	6701
		1		DATE				
		1			1	1		
	1	8952	144	CLAIM DENIED DUE TO AGE RESTRI	 			
				CTIONS FOR TARGET POPULATION	1	1		
3404035		0	0	*** MO DAMA MO DEPOND ***				
3404935	WAYNE CO MENTAL	0		*** NO DATA TO REPORT ***		1		
	HEALTH CTR	1			1	1		
					1	1		
		0	0		0	0	0	0
3404936	UTT OOL OPPET	0	0	*** NO DATA TO REPORT ***	1	1		
2.04220	WILSON-GREENE M ENTAL HEALT	-	-	NO DATA TO REPORT	1	 		
	DNIAD READ!							
							<u> </u>	L
		0	0		0	0	34	34
			1	Í.	1	1		

				Ti and the second secon	1	I	TOTAL	moma r
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	TOTAL
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404937	EDGECOMBE NASH	21	14	DUPLICATE OF CLAIM-SYSTEM				
	MNTL HLTH C							
		8518	3	CLAIM DENIED, SUBMITTED BEYOND	0	17	777	760
				FILING TIMELIMIT. PRIOR				
				FISCAL YEAR DOS (JULY 1 - JUNE				
3404938		0	0	*** NO DATA TO REPORT ***				
3404938	VGFW DBA RIVERS	U	U	NO DATA TO REPORT				
	TONE COUNSE						-	
		0	0		0	0	0	0
3404939	NEUSE MENTAL HE	11	90	CLIENT NOT ELIGIBLE ON SERVICE DATE				
	ALTH CENTER			DATE				
		8599	46	DETAIL NOT COVERED BY COMBINAT	1	187	2103	1916
				ION OF RECIPIENT, PROVIDER AND		-		
				BENEFIT PACKAGE.				
		79	1.7	THIS SERVICE IS NOT PAYABLE TO	1			
	-			YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN	-		 	-
	+	+		THE THE STATE OF THE TWO	 	1	 	
3404941	PITT CO MH/DD/S	8329	458	CLAIM DENIED ATTENDING PROVIDE	1		 	
	AS CENTER			R CANNOT BE THE SAME AS	1			
				THE LMA				
		120	11	CLIENT ID NUMBER MISSING OR IN	0	478	478	0
				VALID. ENTER CID AND SUBMIT AS A NEW CLAIM				
				AS A NEW CLAIM				
		191	8	CLIENT ID NUMBER DOES NOT MATC				
				H PATIENT NAME				
3404942	ROANOKE CHOWANH	8599	28	DETAIL NOT COVERED BY COMBINAT				
	UMAN SERVIC			ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
				BENEFIT PACKAGE.				
		8931	15	AMTNC INELIGIBLE TO RECEIVE SE	19	61	1102	1041
				RVICES IN IPRS.	13		1101	1011
		21	5	DUPLICATE OF CLAIM-SYSTEM				
3404943	ALBEMARLE MENTA	79	84	THIS SERVICE IS NOT PAYABLE TO				
	L HEALTH CE			YOUR SUBMITTED BILLING				
				PROVIDER TYPE AND SPECIALTY IN				
		8931	54	AMTNC INELIGIBLE TO RECEIVE SE	72	240	2772	2532
				RVICES IN IPRS.				└
	+	537	22	PROCEDURE IS NOT COVERED FOR T	1		1	
	+			HIS DATE OF SERVICE	1		 	
							1	
3404944	EASTPOINTE HUMA	8329	76	CLAIM DENIED ATTENDING PROVIDE				
	N SERVICES	<u> </u>		R CANNOT BE THE SAME AS			ļ	
		1		THE LMA			 	
	+	191	58	CLIENT ID NUMBER DOES NOT MATC	-		10	1.555
		1	-	H PATIENT NAME	2	232	1805	1573
								1
							1	
		21	44	DUPLICATE OF CLAIM-SYSTEM				
					1			
3404946	POORHITTI O PRESI	24	142	PROCEDURE CODE, PROCEDURE/MODI	-		 	
	FOOTHILLS AREAM ENTAL HEALT	F -		FIER COMBINATION OR PROCEDURE	 	1	 	
	DATAB HEAD!			CODE/TYPE OF SERVICE COMBINATI	1		 	
		1			1		T	
		8534	43	SERVICE FACILITY LOCATION IS N	0	189	506	317
				OT A VALID IPRS ATTENDING				
	1			PROVIDER. PLEASE VERIFY THE F				
		8599	2	DETAIL NOT COVERED BY COMPINED				
		8599	2	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND				
		8599	2	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				

							TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404957	TIDELAND MENTAL	8518	48	CLAIM DENIED, SUBMITTED BEYOND				
	HEALTH CTR			FILING TIMELIMIT. PRIOR				
				FISCAL YEAR DOS (JULY 1 - JUNE				
		8599	9	DETAIL NOT COVERED BY COMBINAT		72	221	149
				ION OF RECIPIENT, PROVIDER AND		12	221	149
				BENEFIT PACKAGE.				
		191	8	CLIENT ID NUMBER DOES NOT MATC				
		191	0	H PATIENT NAME				.
				n FAILENI NAME				
3404979	NEW RIVER AREAM	11	116	CLIENT NOT ELIGIBLE ON SERVICE				
	H/DD/SA PRO			DATE				
		8931	63	AMTNC INELIGIBLE TO RECEIVE SE	70	290	6249	5959
				RVICES IN IPRS.				
		8599	35	DETAIL NOT COVERED BY COMBINAT			1	-
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				1